EXHIBIT A

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

IN RE: SOCIAL MEDIA CASES	JCCP No. 5255 [Consolidated with JCCP No. 5256]
This Document Relates to: Case Caption and Civil Action No.:	Case No. 22STCV21355 **[PROPOSED] PLAINTIFF FACT SHEET** Full Name of Plaintiff (First, Middle, and Last):

PLAINTIFF FACT SHEET

Please provide the following information for each plaintiff who claims that use of Defendants' platforms (Facebook, Instagram, Snapchat, TikTok, and YouTube) caused them (or a person who died) injury as alleged in the above-captioned litigation. In completing this Plaintiff Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, provide as much information as you can (including approximate times and dates), including by review of documents or materials in your or your attorneys' custody or possession. This Plaintiff Fact Sheet is an electronic version that expands to accommodate as much information as is necessary to fully answer any of these questions, including by adding rows or columns to tables. You must fill out the applicable appendix for each entity you have named as a Defendant. Please do not leave any questions unanswered or blank.

You may and should consult with your attorney if you have any questions regarding the completion of this form.

This Plaintiff Fact Sheet constitutes discovery responses subject to California Code of Civil Procedure. This Plaintiff Fact Sheet and the information provided herein will be used only for this litigation and is designated Confidential under the Protective Order. Plaintiffs do not concede the relevance or admissibility of any of the information herein.

I. CASE INFORMATION

A. Name of the court in which the complaint was initially filed:

_____

B. Case number in court in which complaint was originally filed:

_____

C. Are you alleging in this case that you began using Facebook, Instagram, Snapchat, TikTok, or YouTube when you were under thirteen years old?

[Click here to select your answer.]

****IMPORTANT****

DEFINITION OF "RELEVANT TIME PERIOD"

If your answer to question I.C. is "YES," then the phrase "Relevant Time Period" throughout this Plaintiff Fact Sheet means from the time you turned **SEVEN (7) years old to today.**

If your answer to question I.C. is "NO," then the phrase "Relevant Time Period" throughout this Plaintiff Fact Sheet means from the time you turned **TEN (10) years old to today.**

II. REPRESENTATIVE CAPACITY

Only complete this section if you have filed this lawsuit on behalf of a minor, someone who died, or a person who lacks capacity to complete it on their own. When you complete this section of this form (Section II, "Representative Capacity"), "you" refers to the person filling out this form. When you complete the rest of this form "you" refers to the person you are representing.

A. Name of individual completing this Fact Sheet: _____

B. Your current address: _____

C. What is your relationship to the person upon whose behalf you are completing this Fact Sheet (e.g., parent, guardian, Estate Administrator)?

_____

D. If you represent the estate of someone who died or serve as a successor-in-interest, do you contend that use of Defendants' platforms caused or contributed to that person's death?

[Click here to select your answer.]

E. Have you ever used any Defendant's reporting features to report a negative experience on that platform by the person on whose behalf you are completing this Fact Sheet?

[Click here to select your answer.]

1. **If yes,** please provide the following information:

Platform Involved (select one)	How Many Times Did You Report	Approximate Dates of Report
☐ Facebook ☐ Instagram ☐ Snapchat ☐ TikTok ☐ YouTube		

III. PERSONAL INFORMATION

If you are completing this Fact Sheet for someone else, assume that "you" means the person who used and was allegedly harmed by Defendants' platforms.

A. Legal name: _____

B. Other names by which you have been known (including maiden names, if any):

_____

C. Gender: _____

D. Social Security Number:

_____

E. Date of birth: ***[Click or tap to enter a date.]***

F. List all addresses where you lived for the last six (6) years. Include addresses where you lived while at school, if you lived away from home for school (e.g., boarding school or college). For each address, provide the approximate dates you resided at each location:

Address	Date Range of Residence

G. **Household Information.** Provide the name of all adults who resided in the same household as you for all the addresses you listed above in III.F.

Name	Relationship to You	Date Range the Individual Resided with You

H. **Educational History.**

Provide the following information about your education for the Relevant Time Period:

1. **Primary and Secondary Schools Attended.**

Name of School or Educational Institution	City and State	Dates of Attendance	Grade(s) Completed

2. **Post-Secondary Schools (e.g., Colleges, Trade Schools, Graduate Schools), or Other Educational Institutions, Attended.**

Name of School or Educational Institution	City and State	Dates of Attendance	Degree Awarded	Major or Primary Field

3. During the Relevant Time Period, have you ever been subject to disciplinary action (i.e., detention, in-school suspension, out-of-school suspension, expulsion) by any school or other educational institution?

[Click here to select your answer.]

(a) **If yes,** provide the following information for each incident of disciplinary action to the best of your recollection:

Name of School or Educational Institution	Date of Disciplinary Action	Type of Disciplinary Action (select all that apply)	Grounds for Disciplinary Action
		☐ Detention ☐ In-School Suspension ☐ Out-of-School Suspension ☐ Expulsion	

I. **Previous Interactions with Law Enforcement and the Legal System.**

1. Have you ever been convicted, as an adult, of a felony or a crime involving fraud or dishonesty?

[Click here to select your answer.]

(a) **If yes**, please answer all of the following questions that apply to you for each instance:

Charge(s)	
Court Where Action Was/Is Pending	
Date of Conviction	***[Click or tap to enter a date.]***
Sentence Imposed	

2. Have you ever been subject to a juvenile delinquency proceeding?

[Click here to select your answer.]

3. To the best of your knowledge, has any individual who regularly cared for you ever been convicted of a crime related to your care?

[Click here to select your answer.]

IV. ABUSE / VIOLENCE / DISCRIMINATION

A. Have you ever been the victim of discrimination or harassment on the basis of race/ethnicity, national origin, sex, sexual orientation, gender identity, transgender status, or disability?

[Click here to select your answer.]

1. **If yes**, please select one of the following options to indicate when the discrimination or harassment occurred:

[Click here to select your answer.]

B. Have you ever been the victim of bullying, cyberbullying, verbal abuse, or emotional neglect?

[Click here to select your answer.]

1. **If yes**, please select one of the following options to indicate when the bullying, cyberbullying, verbal abuse, or emotional neglect occurred:

[Click here to select your answer.]

C. Have you ever been the victim of physical abuse, physical assault, or physical neglect?

[Click here to select your answer.]

1. **If yes**, please select one of the following options to indicate when the physical abuse, physical assault, or physical neglect occurred:

[Click here to select your answer.]

D. Have you ever been the victim of rape, sexual abuse, or sexual assault?

[Click here to select your answer.]

1. **If yes**, please select one of the following options to indicate when the rape, sexual abuse, or sexual assault occurred:

[Click here to select your answer.]

E. Have you ever experienced violence or threats of violence (e.g., a shooting, a threatened shooting, or a bombing) in a school, place of worship, your home, or other place?

[Click here to select your answer.]

1. **If yes**, please select one of the following options to indicate when the violence or threats of violence occurred:

[Click here to select your answer.]

F. Have you ever been the victim of a crime against your person not listed above?

[Click here to select your answer.]

1. **If yes**, please select one of the following options to indicate when the crime against your person occurred:

[Click here to select your answer.]

V. EMPLOYMENT AND MILITARY HISTORY

A. Complete the chart below detailing your current employment and all prior employment from when you were fourteen years old through today. Please include any part-time jobs.

Employer	City and State	Date Range of Employment (Month/Year to Month/Year)	Occupation/ Position/Title	Was Your Reason for Leaving Related to Medical, Physical, Psychiatric, Psychological, or Emotional Reasons?
				[Click here to select your answer.]

B. Have you ever served in any branch of the military?

[Click here to select your answer.]

1. **If yes**, provide the following information:

   (a) Branch of service: _____

   (b) Rank upon discharge: _____

   (c) Type of discharge: _____

VI. MEDICAL BACKGROUND

You must complete and execute the attached authorization to release your medical records and answer the following questions.

A. For the Relevant Time Period, identify each healthcare provider that you saw on an outpatient basis for any physical, mental, or neurodevelopmental condition that lasted more than three months. Include all doctors, psychiatrists, dieticians, nutritionists, neuropsychologists, psychologists, therapists, licensed clinical social workers, nurse practitioners, and physician assistants. *If you saw multiple health care providers within the same medical practice, you are not required to list each doctor, nurse practitioner, or physician assistant you may have seen as part of that group; rather, include the name of the health care provider you primarily saw at the medical practice, and identify the medical specialties of all healthcare providers you saw.*

Name of Medical Practice or Provider	Specialty	Provider's Address, Phone Number, and Email	Date Range as Patient	Condition/Reason for Consultation

B. Identify every **hospital, clinic, or facility** where you were admitted as an in-patient or presented for an emergency room visit for any physical, mental, or neurodevelopmental condition or treatment/surgery during the Relevant Time Period. *You may exclude emergency room visits for common colds, viruses, or high fevers.*

Dates of ER Visit or Hospital Admission and Discharge	Name and Address of Facility	Reason for Admission	Treatment Received

C. List **all** prescription anti-depressants, anti-anxiety medications, anti-psychotic medications, and other medications for the treatment of any mental health problem that you took for three (3) months or more during the Relevant Time Period:

Medication	Date Range of Use	Prescribing Physician or Healthcare Provider (Name, Address, and Phone Number)	Pharmacy Used (Name, Address, and Phone Number)
[Click here to select or write in a medication.]			

D. Except for those pharmacies identified in your response to question VI.C, identify every pharmacy that has dispensed medication to you during the Relevant Time Period:

Name of Pharmacy	Address and Phone Number	Name of Medication(s) Dispensed	Date Range You Used Pharmacy

E. Please identify whether you have ever experienced the following conditions and provide the requested information.

Injury, Illness, or Condition (check all that apply)	Date Injury, Illness or Condition Began	If Not Ongoing, Date Injury, Illness, or Condition Ended
☐ Anxiety	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Depression	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Body dysmorphia[1]	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Anorexia	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Bulimia	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Binge Eating Disorder	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Other eating disorder (specify): _____	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Sleep disorder(s)	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Self-harm	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Suicidal thoughts	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Suicide attempt(s)	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Death by suicide	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Other Injury You Attribute to Conduct of a Defendant (specify): _____	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***

VII. ALLEGED INJURIES, ILLNESSES, AND CONDITIONS

A. Identify all physical and mental injuries, illnesses, or conditions that you allege were caused or worsened by Defendant's platforms.

Injury, Illness, or Condition (check all that apply)	Date Injury, Illness, or Condition Began	If Not Ongoing, Date Injury, Illness, or Condition Ended
☐ Social media addiction	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Anxiety	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Depression	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Body dysmorphia[2]	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Anorexia	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Bulimia	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***

[1] An unreasonable preoccupation with an imagined defect in appearance that causes clinically significant distress or impairment in social, occupational or other areas of functioning.

[2] An unreasonable preoccupation with an imagined defect in appearance that causes clinically significant distress or impairment in social, occupational or other areas of functioning.

☐ Binge Eating Disorder	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Other eating disorder (specify): _____	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Sleep disorder(s)	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Self-harm	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Suicidal thoughts	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Suicide Attempt(s)	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Death by suicide	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***
☐ Other Injury You Attribute to Conduct of a Defendant (specify): _____	***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***

B. Diagnosis of Alleged Injuries, Illnesses, or Conditions

1. Have you been diagnosed by a healthcare professional for any injury, illness, or condition identified in VII.A?

[Click here to select your answer.]

(a) **If yes,** please provide the following information:

Injury, Illness, or Condition Diagnosed (list all that apply)	Name of Diagnosing Provider/ Facility/Counselor	Address of Provider/Facility/Counselor

C. Treatment of Alleged Injuries, Illnesses, or Conditions

1. Have you sought medical treatment for any of the injury, illness, or condition identified in VII.A? Medical treatment includes counseling or therapy sought for psychological, psychiatric, mood, or behavioral disorders or conditions, as well as social, emotional, or other related services at a community health center, school, or other educational institution you attended.

[Click here to select your answer.]

(a) **If yes,** please provide the following information:

Injury, Illness, or Condition Treated (list all that apply)	Name of Provider/ Facility/Counselor	Address of Provider/Facility/ Counselor	Date Range of Treatment	Treatment Received

2. Have you been hospitalized or received in-patient treatment for any of the injury, illness, or condition identified in VII.A?

[Click here to select your answer.]

(a) **If yes,** please provide the following information:

Injury, Illness, or Condition Treated (list all that apply)	Type of Facility	Name and Address	Date of Admission	Date of Discharge	Treatment Received
	[Choose an item.]		***[Click or tap to enter a date.]***	***[Click or tap to enter a date.]***	

3. Has any physician or other healthcare provider told you that any injury, illness, or condition identified in VII.A is related to your use of any of Defendants' platforms? *You do not need to list any retained expert witnesses.*

[Click here to select your answer.]

(a) **If yes**, provide the physician's or healthcare provider's name and address and the approximate date of that discussion:

Healthcare Provider's Name	Address	Approximate Date of Discussion
		[Click or tap to enter a date.]

VIII. INSURANCE

A. Provide the following information for each private or public health insurance program with whom you had health insurance coverage during the Relevant Time Period. Include all private insurance and public assistance, if applicable:

Name and Address of Insurance Company or Public Assistance	Policy Number	Name of Policy Holder	Approx. Dates of Coverage

IX. ALCOHOL, TOBACCO, AND DRUG USE

A. Alcohol

1. During the Relevant Time Period, have you consumed alcohol regularly (i.e., once or more per week)?

[Click here to select your answer.]

2. Have you ever sought treatment or been given a professional recommendation or referral for treatment for alcohol addiction?

[Click here to select your answer.]

3. Have you ever received treatment for alcohol addiction?

[Click here to select your answer.]

(a) If yes, when? _____

B. Tobacco

1. During the Relevant Time Period, have you used tobacco (including cigarettes, cigars, pipes, chewing tobacco/snuff, vaping devices, dissolving tobacco, hookah, and/or electronic cigarettes) regularly (i.e., once or more per week)?

[Click here to select your answer.]

2. Have you ever sought treatment or been given a professional recommendation or referral for treatment for a tobacco-related addiction?

[Click here to select your answer.]

3. Have you ever received treatment for a tobacco-related addiction?

[Click here to select your answer.]

(a) If yes, when? _____

C. Drugs

1. During the Relevant Time Period, have you consumed or ingested (in any manner, including swallowing, smoking, snorting, injecting, or using suppositories) recreational drugs (i.e., legal or illegal drugs used without medical supervision)?

[Click here to select your answer.]

2. Have you ever sought treatment or been given a professional recommendation or referral for treatment related to drug use?

[Click here to select your answer.]

3. Have you ever received treatment related to drug use?

[Click here to select your answer.]

(a) If yes, when? _____

D. Video Games

1. Have you played video games during the Relevant Time Period?

[Click here to select your answer.]

(a) **If yes**, provide the following information:

(i) At any point during the Relevant Time Period, did you play video games more than two hours per day or 14 hours per week?

[Click here to select your answer.]

(ii) Have you ever sought treatment or been given a professional recommendation or referral for treatment related to gaming?

[Click here to select your answer.]

(iii) Have you ever received treatment related to gaming?

[Click here to select your answer.]

(A) If yes, when? _____

E. Gambling

1. During the Relevant Time Period, have you engaged in gambling regularly (i.e., once or more per week)

[Click here to select your answer.]

2. Have you ever sought treatment or been given a professional recommendation or referral for treatment related to gambling?

[Click here to select your answer.]

3. Have you ever received treatment related to gambling?

[Click here to select your answer.]

(a) If yes, when? _____

F. Have you ever received treatment for any other addiction?

[Click here to select your answer.]

1. **If yes,** please indicate the addiction(s) for which you received treatment:

_____

X. DAMAGES

A. Are you claiming any lost wages or earning capacity?

[Click here to select your answer.]

1. **If yes**, please provide the following information:

(a) Provide your annual income for each year during the period beginning at age fourteen (14) through today:

Year	Gross Annual Income

(b) From age 14 to today, has any doctor told you that you should not work for some period of time as a result of the injuries you allege in this case?

[Click here to select your answer.]

(i) **If yes**, state the name(s) and address(es) of such health care provider(s):

_____

(c) From age 14 to today, have you quit or taken a medical leave(s) of absence from any job as a result of the injuries you allege in this case?

[Click here to select your answer.]

(i) **If yes**, identify each employer from which you quit or took leave and when:

_____

B. Do you claim medical expenses (including for mental health, psychiatric, psychological, or other treatment) as a result of the injuries you allege in this case?

[Click here to select your answer.]

1. **If yes,** please approximate the total amount of medical expenses you are claiming:

_____

C. Do you claim your education was disrupted (e.g., disciplinary issues, impact on grades, impact on attendance, etc.) as a result of your use of Defendants' platforms?

[Click here to select your answer.]

1. **If yes,** answer the following:

(a) During the Relevant Time Period, have you ever received remedial or supplemental academic, social, or emotional services at a community center, school, or educational institution you attended?

[Click here to select your answer.]

(i) **If yes**, provide the following information:

Name of Community Center, School, or Educational Institution	Date Range of Services	Description of Services Provided
		[Click here to make your selection.]

D. Is anyone claiming loss of consortium and/or loss of services as a result of your use of Defendants' platforms?

[Click here to select your answer.]

1. **If yes,** please identify all persons claiming loss of consortium and/or loss of services, to the best of your knowledge, and your relationship to each person (e.g., spouse, child):

Name	Address	Relationship

XI. ELECTRONICS USAGE

A. At what age did you first have regular access to a mobile phone, tablet, or computer (i.e. once per week or more)?

_____

XII. SOCIAL MEDIA USE

A. Identify whether you used the following platforms (fill in all that apply), the age at first use, and the approximate dates of use:

Platform	Have You Used This Platform?	Age at First Use	Date Range of Use
Facebook	***[Click here to select your answer.]***		
Instagram	***[Click here to select your answer.]***		
Snapchat	***[Click here to select your answer.]***		
TikTok	***[Click here to select your answer.]***		
YouTube	***[Click here to select your answer.]***		

B. To the best of your ability, please estimate your ***average*** usage of each Defendant's platform:

Platform	Average Number of Days Accessed Per Week	Average Number of Minutes Per Day on Days You Accessed	Average Number of Times Accessed Per Day on Days You Accessed
Facebook			
Instagram			

Snapchat			
TikTok			
YouTube			

C. To the best of your ability, please estimate your ***average nightly*** usage of each Defendant's platform between the hours of 10:30 P.M. and 6 A.M.:

Platform	Average Number of Nights Accessed Per Week	Average Number of Minutes Per Night on Nights You Accessed	Average Number of Times Accessed Per Night on Nights You Accessed
Facebook			
Instagram			
Snapchat			
TikTok			
YouTube			

D. To the best of your ability, please estimate your ***peak*** usage of each Defendant's platform:

Platform	Age at Peak Usage	Approximate Minutes Per Day at Peak Usage
Facebook		
Instagram		
Snapchat		
TikTok		
YouTube		

E. For each Defendant's platform, have you ever created an account(s) with an incorrect date of birth or age?

1. Facebook ***[Click here to select your answer.]***

2. Instagram ***[Click here to select your answer.]***

3. Snapchat ***[Click here to select your answer.]***

4. TikTok ***[Click here to select your answer.]***

5. YouTube ***[Click here to select your answer.]***

F. Have you used any other social media platforms?

[Click here to select your answer.]

1. **If yes**, identify the platform, the username(s) you used, the email address(es) you used, the approximate dates of use, your age at first use, and your best estimate of your average frequency of use:

Platform	Username(s)	Email Address(es)	Approximate Dates of Use	Age at Time of First Use	Average Frequency of Use When You Used This Platform
					[Click here to select your answer.]

G. If you have ever tried to delete or deactivate your Facebook, Instagram, Snapchat, TikTok, or YouTube account, provide the following information:

Platform	Delete or Deactivate?	Approximate Date of Attempt	Did You Succeed?
[Click here to select your answer.]		***[Click or tap to enter a date.]***	***[Click here to select your answer.]***

H. If you have ever used any of Defendants' platforms through another person's account, provide the following information regarding those accounts if known:

Platform	Account Username	Email Address Associated with Account (if known)	Accountholder's Name	Accountholder's Relationship to You	Date Range of Your Use of the Account
[Click here to select your answer.]					

I. Have you ever used any app or electronic mechanism to keep content on a device private, such as Calculator+, Hide it Pro (HIP), Vault, AppLock, Secret Calculator?

[Click here to select your answer.]

1. **If yes,** identify the following information:

App or Mechanism Used	Approximate Date App Was Downloaded	Apps/Content Hidden in App	App Username (If Any)

J. Have you ever been paid by a Defendant in connection with your use of their platform?

[Click here to select your answer.]

1. **If yes**, identify the platform(s): _____

K. Do you claim injury or damage as a consequence of your participation in a "challenge" on any of Defendants' platforms?

[Click here to select your answer.]

1. **If yes,** identify the following information:

Name of Challenge	Approximate Date You First Saw the Challenge Attempted	Platform(s) on Which You Observed and/or Participated in the Challenge	Injury or Damage Caused by the Challenge
	[Click or tap to enter a date.]	☐ Facebook ☐ Instagram ☐ Snapchat ☐ TikTok ☐ YouTube	

L. Do you claim that any Defendant facilitated the spread of sexually explicit media depicting or relating to you?

[Click here to select your answer.]

1. If yes, identify the platform(s) on which this occurred:

Platform(s) Involved (select all that apply)
☐ Facebook ☐ Instagram ☐ Snapchat ☐ TikTok

☐ YouTube

2. Was any other person involved in facilitating the spread of sexually explicit media depicting or relating to you?

[Click here to select your answer.]

XIII. DEFENDANTS' PLATFORMS

A. Accessing Defendants' Platforms.

1. What devices have you used on a routine basis to access Defendants' platforms?

☐ Personal phone ☐ Personal tablet ☐ Personal computer	☐ Parent or guardian's phone ☐ Friend or sibling's phone ☐ Family tablet or computer	☐ School tablet or computer ☐ Other: _____

2. Have you or anyone else placed or attempted to place restrictions on your access to Defendants' platforms on the devices listed above (e.g., through Screen Time, internet network, physical removal, etc.)?

[Click here to select your answer.]

B. **Reporting on Defendants' Platforms.** If you have ever used any Defendant's reporting features to report a negative experience on that platform, provide the following information:

Platform Involved (select one)	How Many Times Did You Report	Approximate Dates of Report
☐ Facebook ☐ Instagram ☐ Snapchat ☐ TikTok ☐ YouTube		

XIV. FACT WITNESSES

A. Please identify the five individuals (including, but not limited to, family members, friends, educators, and employers) other than your attorney(s) and healthcare providers who you believe possess the most significant information concerning: (1) your use of social media and (2) your claimed injuries, illnesses, and/or conditions:

Name	Address	Relationship to You	Information You Believe They Possess

XV. AUTHORIZATIONS

For all authorizations listed herein, the starting date for the records release is the beginning of the Relevant Time Period to today.

A. Authorizations for Release of Health Information Pursuant to HIPAA

Please provide a signed (but undated) Limited Authorization to Disclose Health Information Pursuant to HIPAA, attached as **Exhibit "A-1**," and a signed (but undated) Limited Authorization to Disclose Psychological, Psychiatric and Other Mental Health Information, attached as **Exhibit A-2**.

B. If you are claiming lost wages or earning capacity:

1. Please provide a signed (but undated) Authorization to Disclose Employment Records, attached as **Exhibit "B."**

2. Please provide a signed (but undated) Authorization for Release of Workers' Compensation Records, attached as **Exhibit "C."**

3. Please provide a signed (but undated) Authorization for Release of Disability Claims Records, attached as **Exhibit "D."**

C. Authorization for Release of Educational Records

Please provide a signed (but undated) Authorization for Release of Educational Records, attached as **Exhibit "E."**

D. Authorization for Release of Insurance Records

Please provide a signed (but undated) Authorization to Disclose Insurance Information, attached as **Exhibit "F."**

E. Authorization for Release of Medicare and Medicaid Records.

Please provide a signed (but undated) Authorization for Release of Medicaid Information, attached as **Exhibit "G,"** and a signed (but undated) Medicare Authorization to Disclose Personal Health Information Form attached as **Exhibit H.**

XVI. DOCUMENTS IN YOUR POSSESSION, CUSTODY, OR CONTROL

For each of the following questions, indicate whether you have any of the specified materials in your possession, custody, or control, and attach a copy of each document in your possession, custody, or control to this Plaintiff Fact Sheet:

A. All non-privileged documents you reviewed that assisted you in the preparation of your answers to the Short-Form Complaint or this Plaintiff Fact Sheet.

[Click here to select your answer.]

B. All educational records pertaining to you that are related to disciplinary actions or the symptoms, side effects, or injuries (including mental, psychological, or psychiatric injuries, if any) you are claiming during the Relevant Time Period.

[Click here to select your answer.]

C. All medical, billing, insurance (including but not limited to your Explanation of Benefits), or other records and/or other documents relating to your use of Defendants' platforms, or the symptoms, side effects, or injuries (including mental, psychological, or psychiatric injuries, if any) you are claiming.

[Click here to select your answer.]

D. All records of expenditures that you contend are attributable to your alleged injury.

[Click here to select your answer.]

E. All documents or materials in your possession relating to your physical or mental condition, or the symptoms, side effects, or injuries (including mental, psychological, or psychiatric injuries, if any) you are claiming.

[Click here to select your answer.]

F. All diary entries; journal entries; notebook entries; posts on social media platforms (including tweets) other than Facebook, Instagram, Snapchat, TikTok, or YouTube; or posts on chat rooms, blogs, message boards, and online support groups made during the Relevant Time Period in which you have discussed the injuries you are claiming.

[Click here to select your answer.]

G. If you are making a claim for lost wages or lost earning capacity, your W-2s from the time you were fourteen through today, for each year you have filed a tax return.

[Click here to select your answer.]

H. If you have been the claimant or subject of any Social Security or other disability proceeding related to the injuries you are claiming, all documents in your possession relating to such proceeding.

[Click here to select your answer.]

I. For deceased plaintiffs, the death certificate of the person who died and any certificate or letters of administration that establish the authority of the Representative bringing this lawsuit on behalf of the person who died.

[Click here to select your answer.]

XVII. **DECLARATION**

I declare under penalty of perjury that, at the time I completed this Plaintiff Fact Sheet, all of the information provided is true and correct to the best of my knowledge, that I have supplied all the documents requested in this Plaintiff Fact Sheet, to the extent that such documents are in my possession, custody, or control, and that I have supplied the applicable Authorizations attached to this declaration.

Date: _____ Signature: _____

Printed name: _____
(Plaintiff or person authorized to sign)

On behalf of (if applicable): _____
(Minor)

META APPENDIX

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

IN RE: SOCIAL MEDIA CASES This Document Relates to: Case Caption and Civil Action No.:	JCCP No. 5255 [Consolidated with JCCP No. 5256] Case No. 22STCV21355 **[PROPOSED] PLAINTIFF FACT SHEET – Appendix for Meta** Full Name of Plaintiff (First, Middle, and Last):

PLAINTIFF FACT SHEET – Appendix for Meta

Complete the following questions only if you have named Meta as a defendant.

A. Facebook

1. Identify whether you have used or encountered the following Facebook features, and state whether you contend that this feature contributed to your injuries:

Feature	Have you used or encountered this feature?	Do you contend that this feature contributed to your injuries?
Accounts to Follow	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Discovery	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Facebook Chat/Messenger	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Facebook Live	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Facebook/Messenger Kids	***[Click here to select your answer.]***	***[Click here to select your answer.]***
"For you"	***[Click here to select your answer.]***	***[Click here to select your answer.]***

Feature	Have you used or encountered this feature?	Do you contend that this feature contributed to your injuries?
Geotags	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Groups You Should Join	***[Click here to select your answer.]***	***[Click here to select your answer.]***
"Infinite scrolling"	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Like/Reactions	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Newsfeed	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Notifications	***[Click here to select your answer.]***	***[Click here to select your answer.]***
People You May Know	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Reels	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Stories	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Vanish Mode	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Video auto-play	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Watch	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Other feature you contend contributed to your injuries (specify): _____	***[Click here to select your answer.]***	***[Click here to select your answer.]***

2. Select all of the following categories of material that you saw on Facebook, and provide the related information:

Material	Have You Seen This Material on Facebook?	How Often Did You See This Material on Facebook?
Body image comparison	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Eating disorders	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Self-harm or suicide	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Violence	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Drugs	***[Click here to select your answer.]***	***[Click here to select your answer.]***

3. Select any of the following experiences you allege happened to you on Facebook, and provide the related information:

Experience	Have You Had This Experience on Facebook?	How Often Did You Have This Experience on Facebook?
Bullying	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Sexual Grooming	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Sextortion	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Receipt or transmission of sexually explicit media	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Receipt of unsolicited, inappropriate contact from an adult, when you were under 18	***[Click here to select your answer.]***	***[Click here to select your answer.]***

B. Instagram

1. Identify whether you have used or encountered the following Instagram features, and state whether you contend that this feature contributed to your injuries.

Feature	Have you used or encountered this feature?	Do you contend that this feature contributed to your injuries?
"Because you watched"	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Explore	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Feed	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Filters	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Hashtags	***[Click here to select your answer.]***	***[Click here to select your answer.]***
IGTV	***[Click here to select your answer.]***	***[Click here to select your answer.]***
"Infinite scrolling"	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Instagram Direct	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Instagram Live	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Likes/Reactions	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Notifications	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Offline mode	***[Click here to select your answer.]***	***[Click here to select your answer.]***

Feature	Have you used or encountered this feature?	Do you contend that this feature contributed to your injuries?
Photo Bomb	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Reels	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Saved	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Stories/Story Reactions	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Suggested for you	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Vanish Mode	***[Click here to select your answer.]***	***[Click here to select your answer.]***
View count	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Viewing when others are active or were recently active	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Other feature you contend contributed to your injuries (specify): _____	***[Click here to select your answer.]***	***[Click here to select your answer.]***

2. Select all of the following categories of material that you saw on Instagram, and provide the related information:

Material	Have You Seen This Material on Instagram?	How Often Did You See This Material on Instagram?
Body image comparison	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Eating disorders	***[Click here to select your answer.]***	***[Click here to select your answer.]***

Self-harm or suicide	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Violence	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Drugs	***[Click here to select your answer.]***	***[Click here to select your answer.]***

3. Select any of the following experiences you allege happened to you on Instagram, and provide the related information:

Experience	**Have You Had This Experience on Instagram?**	**How Often Did You Have This Experience on Instagram?**
Bullying	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Sexual Grooming	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Sextortion	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Receipt or transmission of sexually explicit media	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Receipt of unsolicited, inappropriate contact from an adult, when you were under 18	***[Click here to select your answer.]***	***[Click here to select your answer.]***

SNAP APPENDIX

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

IN RE: SOCIAL MEDIA CASES This Document Relates to: Case Caption and Civil Action No.:	JCCP No. 5255 [Consolidated with JCCP No. 5256] Case No. 22STCV21355 **[PROPOSED] PLAINTIFF FACT SHEET – Appendix for Snap** Full Name of Plaintiff (First, Middle, and Last):

PLAINTIFF FACT SHEET – Appendix for Snap

Complete the following questions only if you have named Snap as a defendant.

A. Identify whether you have used or encountered the following Snapchat features, and state whether you contend that this feature contributed to your injuries.

Feature	Have you used or encountered this feature?	Do you contend that this feature contributed to your injuries?
Sending or receiving Chats or Snaps	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Using lenses and filters	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Communicating with other users via voice or video calling	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Posting Stories	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Checking and/or monitoring your Story views	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Viewing others' Stories	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Viewing content on Spotlight	***[Click here to select your answer.]***	***[Click here to select your answer.]***

Feature	Have you used or encountered this feature?	Do you contend that this feature contributed to your injuries?
Posting content on Spotlight	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Viewing content on Discover	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Checking and/or monitoring your Spotlight content views	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Using Snap Map	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Maintaining and/or monitoring Snap Streaks	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Monitoring your Snapscore	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Viewing your Trophies or Charms	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Adding friends via Quick Add	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Saving Snaps to My Eyes' Only	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Using Stickers	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Using SnapKidz	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Sending or receiving Snapcash	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Use of the add all button	***[Click here to select your answer.]***	***[Click here to select your answer.]***

C. **Interactions with Other Users on Snapchat.** Did you access a controlled substance on Snapchat?

[Click here to select your answer.]

1. If you exchanged messages with another user regarding obtaining a controlled substance, fill out the following table for each occurrence (copy as many rows as needed):

Approximate Date of Interaction	Did You Know the Person Before This Interaction?	How Did You and the Person Connect on Snapchat?
[Click or tap to enter a date.]	***[Click here to select your answer.]***	***[Click here to select your answer.]***

D. Select any of the following experiences you allege happened to you on Snapchat:

Experience	Have You Had This Experience on Snapchat?
Bullying	***[Click here to select your answer.]***
Sexual Grooming	***[Click here to select your answer.]***
Sextortion	***[Click here to select your answer.]***
Receipt or transmission of sexually explicit media	***[Click here to select your answer.]***
Receipt of unsolicited, inappropriate contact from an adult, when you were under 18	***[Click here to select your answer.]***

TIKTOK APPENDIX

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

IN RE: SOCIAL MEDIA CASES	JCCP No. 5255 [Consolidated with JCCP No. 5256]
This Document Relates to: Case Caption and Civil Action No.:	Case No. 22STCV21355 **[PROPOSED] PLAINTIFF FACT SHEET – Appendix for TikTok** Full Name of Plaintiff (First, Middle, and Last):

PLAINTIFF FACT SHEET – Appendix for TikTok

Complete the following questions only if you have named TikTok as a defendant.

A. Identify whether you have used or encountered the following TikTok features, and state whether you contend that this feature contributed to your injuries:

Feature	Have you used or encountered this feature?
For You Page (FYP)	***[Click here to select your answer.]***
TikTok Live	***[Click here to select your answer.]***
TikTok Now	***[Click here to select your answer.]***
Duet	***[Click here to select your answer.]***
Find Friends / People You May Know	***[Click here to select your answer.]***
Stories	***[Click here to select your answer.]***
Direct Messaging	***[Click here to select your answer.]***
Filters	***[Click here to select your answer.]***
"Likes"	***[Click here to select your answer.]***
Created content	***[Click here to select your answer.]***
Uploaded videos	***[Click here to select your answer.]***
Gift	***[Click here to select your answer.]***
Family Pairing	***[Click here to select your answer.]***
Screen Management tools (e.g., setting time limits)	***[Click here to select your answer.]***
Other feature you contend contributed to your injuries (specify): _____	***[Click here to select your answer.]***

E. Select all of the following categories of material that have been presented to you on TikTok:

Material	Have You Seen This Material on TikTok?	How Often Did You See This Material on TikTok?
Body image comparison	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Eating disorders	***[Click here to select your answer.]***	***[Click here to select your answer.]***
Violence	***[Click here to select your answer.]***	***[Click here to select your answer.]***

Material	Have You Seen This Material on TikTok?	How Often Did You See This Material on TikTok?
Drugs	***[Click here to select your answer.]***	***[Click here to select your answer.]***

F. Select any of the following experiences you allege happened to you on TikTok:

Experience	Have You Had This Experience on TikTok?
Bullying	***[Click here to select your answer.]***
Sexual Grooming	***[Click here to select your answer.]***
Sextortion	***[Click here to select your answer.]***
Receipt or transmission of sexually explicit media	***[Click here to select your answer.]***

YOUTUBE APPENDIX

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

IN RE: SOCIAL MEDIA CASES This Document Relates to: Case Caption and Civil Action No.:	JCCP No. 5255 [Consolidated with JCCP No. 5256] Case No. 22STCV21355 **[PROPOSED] PLAINTIFF FACT SHEET – Appendix for YouTube** Full Name of Plaintiff (First, Middle, and Last):

PLAINTIFF FACT SHEET – Appendix for YouTube

Complete the following questions only if you have named YouTube as a defendant.

A. Indicate whether you have engaged with the following YouTube features (check all that apply), and, if applicable, the approximate frequency of doing so.

Feature	Have you used or encountered this feature?	Do you contend that this feature contributed to your injuries?
Watching a video with Autoplay disabled	***[Click here to select your answer.]***	☐ Yes ☐ No
Watching a video through YouTube Kids (rather than through the regular YouTube website or app)	***[Click here to select your answer.]***	☐ Yes ☐ No
Liking or disliking a video	***[Click here to select your answer.]***	☐ Yes ☐ No
Commenting on a video or responding to a comment on a video	***[Click here to select your answer.]***	☐ Yes ☐ No
Clicking on a hyperlink within a video description or a comment posted to a video	***[Click here to select your answer.]***	☐ Yes ☐ No

Feature	Have you used or encountered this feature?	Do you contend that this feature contributed to your injuries?
Viewing YouTube Shorts	***[Click here to select your answer.]***	☐ Yes ☐ No
Using Super Chat	***[Click here to select your answer.]***	☐ Yes ☐ No
Using Super Stickers	***[Click here to select your answer.]***	☐ Yes ☐ No
Uploading videos to YouTube	***[Click here to select your answer.]***	☐ Yes ☐ No
Participating in a user survey promoted by YouTube	***[Click here to select your answer.]***	☐ Yes ☐ No

Please complete the following questions only if you have watched videos on YouTube.

B. Viewing Content on YouTube

1. To the best of your ability, please estimate how often you watch videos on YouTube without logging in with a YouTube account:

Average Number of Minutes Per Day	Average Number of Times Accessed Per Day

2. To the best of your ability, please estimate how often you watch videos on YouTube while using incognito or private mode on your web browser:

Average Number of Minutes Per Day	Average Number of Times Accessed Per Day

3. Has your parent, legal guardian, or any other person ever used any of YouTube's parental control features for your YouTube account(s)?

[Click here to select your answer.]

(a) **If yes:** Specify whether your parent, legal guardian, or any other person ever used the following parental control features:

(i) Family Link
Yes ☐ No ☐ I don't know ☐

(ii) Supervised experience
Yes ☐ No ☐ I don't know ☐

(iii) Disable search feature
Yes ☐ No ☐ I don't know ☐

(iv) Disable watch history feature
Yes ☐ No ☐ I don't know ☐

(v) Review search history
Yes ☐ No ☐ I don't know ☐

(vi) Review watch history
Yes ☐ No ☐ I don't know ☐

(vii) Block content or channels
Yes ☐ No ☐ I don't know ☐

(viii) Adjust content rating settings
Yes ☐ No ☐ I don't know ☐

(ix) Turn on watch time limits
Yes ☐ No ☐ I don't know ☐

(x) Only parent-approved content viewable
Yes ☐ No ☐ I don't know ☐

(xi) Make user information private
Yes ☐ No ☐ I don't know ☐

(xii) Disable personalized advertisements
Yes ☐ No ☐ I don't know ☐

Exhibit "A-1"

[Limited Authorization to Disclose Health Information Pursuant to HIPAA]

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Excluding Psychiatric, Psychological, and Mental Health Treatment Notes/Records)
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

In re Social Media Adolescent Addiction/Personal Injury Products Liability Litigation, JCCP No. 5255, Superior Court of the State of California for the County of Los Angeles

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Patient | Date of Birth | Social Security Number

This will authorize you to furnish to **[to be determined by the Parties on terms for medical records collection**] complete copies of the following records and/or information for the time period from _____ to the present:

All medical records and information (including those that may include protected health information) regarding the individual identified by name, DOB and Social Security number above, including relating to inpatient, outpatient, and emergency room treatment. Such records and information include, but are not limited to, all questionnaires/histories; clinical charts and/or reports; order sheets; progress notes; physician's notes; nurse's notes; physician's assistant's notes; social worker's notes; admission records; discharge summaries; requests for and reports of consultations; patient consent forms; copies (not originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy studies, films or imaging and corresponding reports; laboratory, pathology, histology, cytology, and autopsy reports; test results; records of drug and/or alcohol abuse; correspondence, emails, logs, pathology slides, H&P's, patient intake forms, insurance records, claim forms, and records received from other health professionals.

All pharmacy/prescription records, including NDC numbers and drug information handouts/monographs.

All billing records, including statements of account, itemized bills, invoices and insurance records.

Notwithstanding the broad scope of the above disclosure requests, the undersigned does not authorize the disclosure of notes or records pertaining to psychiatric, psychological, or mental health treatment or diagnosis as such terms are defined by HIPAA, 45 CFR § 164.501. However, a separate authorization may accompany this authorization for the release of psychological, psychiatric, and/or mental health records and information.

1. To my medical provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing, please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.**

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to **[to be determined by the Parties on terms for medical records collection**]. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or**

human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.

Name of Patient	Name of Patient's Representative (if applicable)
Former/Alias/Maiden Name of Patient	Description of Authority to Act for Patient
Address of Patient	Signature of Patient or Representative
Date	

Exhibit "A-2"

[Limited Authorization to Disclose Psychological, Psychiatric and Other Mental Health Information]

LIMITED AUTHORIZATION TO DISCLOSE PSYCHOLOGICAL, PSYCHIATRIC AND OTHER MENTAL HEALTH INFORMATION

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

In re Social Media Adolescent Addiction/Personal Injury Products Liability Litigation, JCCP No. 5255, Superior Court of the State of California for the County of Los Angeles

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Patient | Date of Birth | Social Security Number

This will authorize you to furnish to **[to be determined by the Parties on terms for medical records collection]** complete copies of the following records and/or information for the time period from _____ to the present:

All psychological, psychiatric, and/or mental health records and information (including those that may contain protected health information) regarding the individual identified by name, DOB, and Social Security number above, including relating to inpatient, outpatient and/or emergency room treatment. Such records include, but are not limited to, questionnaires/histories; clinical charts and/or reports; order sheets; progress notes; psychiatric records; psychological records; psychotherapy notes; physician's notes; nurse's notes; physician assistant's notes; therapist, counselor or social worker's notes; treatment plans; admission records; discharge summaries; requests for and reports of consultations; patient consent forms; copies (not originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy studies, films or imaging and corresponding reports; laboratory reports; test results; records of drug and/or alcohol abuse; correspondence, emails, logs, H&P's, patient intake forms, insurance records, claim forms, and records received from other health professionals.

All "psychotherapy notes," as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR § 164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. This authorization does not authorize ex parte communication concerning same.

All pharmacy and prescription records, including NDC numbers and drug information handouts/monographs.

All billing records, including statements of account, itemized bills, invoices, and insurance records.

1. To records provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing, please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.**

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to **[to be determined by the Parties on terms for medical records collection**]. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome**

(AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.

Name of Patient	Name of Patient's Representative (if applicable)
Former/Alias/Maiden Name of Patient	Description of Authority to Act for Patient
Address of Patient	Signature of Patient or Representative
Date	

Exhibit "B"

[Authorization to Disclose Employment Records]

AUTHORIZATION TO DISCLOSE EMPLOYMENT RECORDS

In re Social Media Adolescent Addiction/Personal Injury Products Liability Litigation, JCCP No. 5255, Superior Court of the State of California for the County of Los Angeles

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Employee | Date of Birth | Social Security Number

This will authorize you to furnish to **[to be determined by the Parties on terms for medical records collection**] complete copies of the following records and/or information for the time period from _____ to the present:

> All applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, psychiatric and dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; materials safety data sheets, chemical inventories and environmental monitoring records and all other employee exposure records pertaining to all positions held; and any other records concerning employment with the above-named entity.

1. To records provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing, please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.**

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to **[to be determined by the Parties on terms for medical records collection**]. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this employment/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure employment, employment benefits, or employment accommodations, or to assure medical treatment. I understand that the entity to whom this authorization is directed may not condition medical treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my employment and health records may include information relating to (a) psychiatric, psychological, or mental health information, and (b) to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.**

Name of Employee	Name of Employee's Representative (if applicable)
Former/Alias/Maiden Name of Employee	Description of Authority to Act for Employee
Address of Employee	Signature of Employee or Representative
Date	

Exhibit "C"

[Authorization for Release of Workers' Compensation Records]

AUTHORIZATION FOR RELEASE OF WORKERS COMPENSATION RECORDS

In re Social Media Adolescent Addiction/Personal Injury Products Liability Litigation, JCCP No. 5255, Superior Court of the State of California for the County of Los Angeles

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Worker | Date of Birth | Social Security Number

This will authorize you to furnish to **[to be determined by the Parties on terms for medical records collection**] complete copies of the following records and/or information for the time period from _____ to the present:

All Workers' Compensation claims, including claim petitions, judgments, findings, notices of hearings, hearing records, transcripts, decisions and orders; all depositions and reports of witnesses and expert witnesses; employer's accident reports; all other accident, injury, or incident reports; all medical records; records of compensation payment made; investigatory reports and records; applications for employment; records of all positions held; job descriptions of any positions held; salary records; performance evaluations and reports; statements and comments of fellow employees; attendance records; all physicians', hospital, medical, health reports; physical examinations; records relating to health or disability insurance claims, including correspondence, reports, claim forms, questionnaires, records of payments made to physicians, hospitals, and health institutions or professionals; statements of account, itemized bills or invoices; and any other records relating to the above-named individual. Copies, NOT originals, of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports.

1. To records provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing,**

please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to **[to be determined by the Parties on terms for medical records collection**]. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this workers' compensation/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure employment, employment benefits, or employment accommodations, or to assure medical treatment. I understand that the covered to whom this authorization is directed may not condition medical treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my workers' compensation and health records may include information relating to (a) psychiatric, psychological, or mental health information, and (b) to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.**

Name of Worker	Name of Worker's Representative (if applicable)
Former/Alias/Maiden Name of Worker	Description of Authority to Act for Worker
Address of Worker	Signature of Worker or Representative
Date	

Exhibit "D"

[Authorization for Release of Disability Claims Records]

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** ***ADDRESS OF PERSON OR ORGANIZATION:**

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. [X] Verification of Social Security Number
2. [ ] Current monthly Social Security benefit amount
3. [ ] Current monthly Supplemental Security Income payment amount
4. [ ] My benefit or payment amounts from date _____ to date _____
5. [X] My Medicare entitlement from date _____ to date _____
6. [X] Medical records from my claims folder(s) from date_____ to date_____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. [X] Complete medical records from my claims folder(s)
8. [X] Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)
   Application for SSD and all documents related to the determination for eligibility including any consultative exams, reports, or documents submitted during the appeals process.

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Exhibit "E"

[Authorization for Release of Educational Records]

LIMITED AUTHORIZATION TO DISCLOSE EDUCATIONAL INFORMATION

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03 and the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99))

In re Social Media Adolescent Addiction/Personal Injury Products Liability Litigation, JCCP No. 5255, Superior Court of the State of California for the County of Los Angeles

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Student/Patient | Date of Birth | Social Security Number

This will authorize you to furnish to **[to be determined by the Parties on terms for medical records collection**] complete copies of the following records and/or information for the time period from _____ to the present:

> All educational records and information (including those that may contain protected health information) regarding the individual identified by name, DOB, and Social Security number above, including, but not limited to, the following: application and admission documentation; attendance records; report cards; grades or transcripts; standardized testing and other testing results; placement and other evaluations; honors; awards; diplomas; athletic letters; extra-curricular activities; health and physical examination records; immunization records; nurse's notes and records; guidance counselor's notes and records; social worker's notes and records; other counseling notes or records; disciplinary records (including suspensions or expulsions); letters of recommendation; other correspondence; and any and all other information and records.

1. To records provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing, please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.**

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to

[to be determined by the Parties on terms for medical records collection]. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this educational/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure educational admissions, benefits, or accommodations, or to assure medical treatment. I understand that the entity to whom this authorization is directed may not condition medical treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 34 CFR § 99.30(c) and/or 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my educational and health records may include information relating to (a) psychiatric, psychological, or mental health information, and (b) to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.**

Name of Student	Name of Student's Representative (if applicable)
Former/Alias/Maiden Name of Student	Description of Authority to Act for Student
Address of Student	Signature of Student or Representative
Date	

Exhibit "F"

[Authorization for Release of Insurance Information]

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION

In re Social Media Adolescent Addiction/Personal Injury Products Liability Litigation, JCCP No. 5255, Superior Court of the State of California for the County of Los Angeles

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Insured | Date of Birth | Social Security Number

This will authorize you to furnish to **[to be determined by the Parties on terms for medical records collection**] complete copies of the following records and/or information for the time period from _____ to the present:

> All applications for insurance coverage and renewals; all insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage or claims; all physicians, hospitals, psychiatric, psychological, and dental reports, prescriptions, correspondence, test results, radiology, and any other medical reports and records that were submitted for claims review purposes; any claim record filed; records of any claim paid; records of all litigation; and any other records of any kind concerning or pertaining to the insured.

1. To records provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing, please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.**

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to **[to be determined by the Parties on terms for medical records collection**]. I understand the revocation will not apply to information that has already been released in response to

this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this insurance/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure insurance coverage, insurance benefits, or to assure medical treatment. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my insurance and health records may include information relating to (a) psychiatric, psychological, or mental health information, and (b) to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.**

_____	_____
Name of Insured	Name of Insured's Representative (if applicable)
_____	_____
Former/Alias/Maiden Name of Insured	Description of Authority to Act for Insured
_____	_____
Address of Insured	Signature of Insured or Representative
_____	
Date	

Exhibit "G"

[Authorization for Release of Medicaid Information]

AUTHORIZATION FOR RELEASE OF MEDICAID INFORMATION

In re Social Media Adolescent Addiction/Personal Injury Products Liability Litigation, JCCP No. 5255, Superior Court of the State of California for the County of Los Angeles

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Individual | Date of Birth | Social Security Number

This will authorize you to furnish to **[to be determined by the Parties on terms for medical records collection**] complete copies of the following records and/or information for the time period from _____ to the present:

> All Medicaid records, including explanations of Medicaid benefit records and claims records; any statements, communications, pro reviews, denials, appeals, correspondence, reports, questionnaires or records submitted in connection with claims; all reports from physicians, hospitals, dental providers, prescriptions; correspondence, test results and any other medical records; records of claims paid to or on the behalf of the individual identified by name, DOB, and Social Security number above; records of litigation and any other records of any kind. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

1. To records provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing, please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.**

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to **[to be determined by the Parties on terms for medical records collection**]. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this Medicaid/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure Medicaid coverage, Medicaid benefits, or to assure medical treatment. I understand that the covered entity to whom this authorization is directed may not condition medical treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my Medicaid and health records may include information relating to (a) psychiatric, psychological, or mental health information, and (b) to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.**

Name of Individual	Name of Individual's Representative (if applicable)
Former/Alias/Maiden Name of Individual	Description of Authority to Act for Individual
Address of Individual	Signature of Individual or Representative
Date	

Exhibit “H”

[Medicare Authorization to Disclose Personal Health Information Form]

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

Beneficiary Services:1-800-MEDICARE (1-800-633-4227)
TTY/ TDD:1-877-486-2048

This form is used to advise Medicare of the person or persons you have chosen to have access to your personal health information.

Where to Return Your Completed Authorization Forms:
After you complete and sign the authorization form, return it to the address below:

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

For New York Medicare Beneficiaries ONLY
The New York State Public Health Law protects information that reasonably could identify someone as having HIV symptoms or infection, and information regarding a person's contacts. Because of New York's laws protecting the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV, there are special instructions for how you, as a New York resident, should complete this form.

- For question 2A, check the box for *Limited Information*, even if you want to authorize Medicare to release any and all of your personal health information.

- **Then proceed to question 2B.**

Instructions for Completing Section 2B of the Authorization Form:
Please select one of the following options.

- **Option 1** To **include** all information, in the space provided, write: "all information, including information about alcohol and drug abuse, mental health treatment, and HIV". Proceed with the rest of the form.

- **Option 2** To **exclude** the information listed above, write "Exclude information about alcohol and drug abuse, mental health treatment and HIV" in the space provided. *You may also check any of the remaining boxes and include any additional limitations in the space provided.* For example, you could write "payment information". Then proceed with the rest of the form.

If you have any questions or need additional assistance, please feel free to call us at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Sincerely,

1-800-MEDICARE
Customer Service Representative

Encl.

Information to Help You Fill Out the "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in the privacy notice contained in the Medicare & You handbook. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

If you want 1-800-MEDICARE to give your personal health information to someone other than you, you need to let Medicare know in writing.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example: Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, please explain your relationship to the beneficiary.

Please use this step by step instruction sheet when completing your "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form. Be sure to complete all sections of the form to ensure timely processing.

1. Print the name of the person with Medicare.

   Print the Medicare number exactly as it is shown on the red, white, and blue Medicare card, including any letters (for example, 123456789A).

   Print the birthday in month, day, and year (mm/dd/yyyy) of the person with Medicare.

2. This section tells Medicare what personal health information to give out. Please check a box in 2a to indicate how much information Medicare can disclose. If you only want Medicare to give out limited information (for example, Medicare eligibility), also check the box(es) in 2b that apply to the type of information you want Medicare to give out.

3. This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.

4. Medicare will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization. If you designate an organization, you must also identify one or more individuals in that organization to whom Medicare may disclose your personal health information.

5. The person with Medicare or personal representative must sign their name, fill in the date, and provide the phone number and address of the person with Medicare.

   If you are a personal representative of the person with Medicare, check the box, provide your address and phone number, and attach a copy of the paperwork that shows you can act for that person (for example, Power of Attorney).

6. Send your completed, signed authorization to Medicare at the address shown here on your authorization form.

7. If you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number six on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Medicare.

1-800-MEDICARE Authorization to Disclose Personal Health Information

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. **Print Name** (First and last name of the person with Medicare) _____ **Medicare Number** (Exactly as shown on the Medicare Card) _____ **Date of Birth** (mm/dd/yyyy) _____

2. Medicare will only disclose the personal health information you want disclosed.

   2A: **Check only <u>one</u> box below to tell Medicare the specific personal health information you want disclosed:**

   ☐ Limited Information (go to question 2b)

   ☐ Any Information (go to question 3)

   2B: **Complete <u>only</u> if you selected "limited information". Check all that apply:**

   ☐ Information about your Medicare eligibility

   ☐ Information about your Medicare claims

   ☐ Information about plan enrollment (e.g. drug or MA Plan)

   ☐ Information about premium payments

   ☐ Other Specific Information (please write below; for example, payment information)

   _____

3. **Check only <u>one</u> box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

   ☐ Disclose my personal health information indefinitely

   ☐ Disclose my personal health information for a specified period only
   beginning: (mm/dd/yyyy) _____ and ending: (mm/dd/yyyy) _____

4. Fill in the name and address of the person(s) or organization(s) to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:

1. Name: _____

   Address: _____

   _____

2. Name: _____

   Address: _____

   _____

3. Name: _____

   Address: _____

   _____

5.

I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

_____ _____ _____

Signature Telephone Number Date (mm/dd/yyyy)

Print the address of the person with Medicare (Street Address, City, State, and ZIP)

_____

_____

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

_____

_____

Telephone Number of Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

6. **Send the completed, signed authorization to:**

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

7. **Note:**

You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0930**. The time required to complete this information collection is estimated to average **15 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** ***ADDRESS OF PERSON OR ORGANIZATION:**

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. [X] Verification of Social Security Number
2. [ ] Current monthly Social Security benefit amount
3. [ ] Current monthly Supplemental Security Income payment amount
4. [ ] My benefit or payment amounts from date _____ to date _____
5. [X] My Medicare entitlement from date _____ to date _____
6. [X] Medical records from my claims folder(s) from date_____ to date_____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. [X] Complete medical records from my claims folder(s)
8. [X] Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)
   Application for SSD and all documents related to the determination for eligibility including any consultative exams, reports, or documents submitted during the appeals process.

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)